



*The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108*

CHARLES BAKER
Governor

MARYLOU SUDDERS
Board Chair

KARYN POLITO
Lieutenant Governor

LOUIS GUTIERREZ
Executive Director

**Board of the Commonwealth Health Insurance Connector Authority
Minutes**

Thursday, September 9, 2021
9:00 AM to 11:00 PM

Live Stream

<https://www.youtube.com/user/TheMAHealthConnector>

Attendees: Louis Gutierrez, Michael Chernew, Deputy Commissioner Kevin Beagan (who was sitting by designation on behalf of Commissioner Gary Anderson), Nancy Turnbull, Cassandra Roeder (who was sitting by designation on behalf of Secretary Michael Heffernan), Dimitry Petion, Mark Gaunya, Commissioner Matt Venno, FayeRuth Fisher, Rina Vertes, and Lauren Peters (who was sitting by designation on behalf of Secretary Marylou Sudders)

The meeting was called to order at 9:01 AM.

- I. Minutes:** The minutes of the July 8, 2021 meeting were approved by roll call vote. Mr. Beagan abstained from voting.

- II. Executive Director's Report:** Mr. Gutierrez began the meeting by highlighting a member renewal issue for 2022 coverage. He noted that during the Health Connector's annual renewal process, staff found that a higher number of members (approximately 60 percent) are expected to lose subsidies in 2022 if they do not come into their accounts to validate income information, compared to 20 to 25 percent in prior years. This issue is a result of the IRS automatically amending 2020 tax returns more often than usual due to the tax filing changes created by the American Rescue Plan (ARP) which provided tax relief to people on unemployment income in 2020. Amended returns result in income data that differs from what Exchanges like the Health Connector are required to use to verify subsidy eligibility. These differences cause members to lose their subsidy eligibility until and unless they take steps to verify their income. He noted that the process to verify requires members to update their income in their account by clicking "save". Members will then be updated back into subsidies at the correct level but will likely have to respond to a Request for Information (RFI) notice in the mail to confirm

the change.

Mr. Gutierrez continued by sharing that the Health Connector will communicate with impacted members (an estimated 130,000 individuals) to encourage them to take immediate action. The Health Connector is also working with CMS and other states to find a federal policy solution that will prevent impacted individuals from losing subsidies but there is no guarantee of that. Therefore, the Health Connector is proceeding with a robust communications plan with multiple items directed to members losing subsidies between September and December. Mr. Gutierrez highlighted that Navigators would receive lists of their clients to conduct direct outreach and help them update their information. Additionally, the Health Connector will engage with stakeholders including advocates, carriers, and other assisters to highlight the issue and encourage across the board member support. Finally, he noted that the renewal issue would be highlighted on all the Health Connector's social media platforms and in all Open Enrollment public events. Mr. Gutierrez highlighted the importance of keeping members in subsidies noting that the enhanced ARP subsidies carry through Plan Year 2022 (PY22) and serve as a helpful support for affordability.

Ms. Turnbull observed that the subsidy loss is an ironic and unintended consequence of a good policy change. In response to a question from Ms. Turnbull, Mr. Gutierrez confirmed that the member renewal problem is shared by several states but there are some states that may not feel the impact because they may not be doing certain income verifications. He noted that the Health Connector is working in partnership with other states, outside expertise, and CMS to search for a solution. He also stated that states have not yet broached the subject of the federal role in communicating to impacted individuals if needed, but plan to.

In response to a question from Mr. Petion about options for the 130,000 impacted members if their subsidies do not continue, Mr. Gutierrez stated that the Health Connector is actively exploring options for a softer landing for members and will return to the Board in October with an update.

In response to a question from Dr. Chernew, Mr. Gutierrez clarified that Massachusetts was the first state to uncover this member issue because the Health Connector is among the first to run eligibility redeterminations in anticipation of the new plan year. The issue does not affect members for the balance of 2021 and was found during preliminary eligibility for 2022 which is now complete. Now that notices have been mailed, members need to make changes between now and December 23rd for January enrollment.

In response to a follow-up question from Dr. Chernew about the timing of events from a member's perspective, Mr. Gutierrez clarified that because preliminary eligibility, which is a joint process run with MassHealth, is complete, members will be receiving notices indicating the loss of subsidy. The notice itself asks that the member go to their account to update their income information which will prompt many to do so. In an ordinary year, the roughly 20 to 25 percent of members experiencing subsidy loss gradually decreases over the course of Open Enrollment. This year there is a much steeper curve to work on.

Next, Mr. Gutierrez provided a synopsis of the agenda items before the Board including the Final Seal of Approval (SOA) for Plan Year 2022, background on premium trends over time and Health Care Sharing Ministries (HCSM), and an update on the contact center re-implementation work.

Mr. Gutierrez noted that the current vendor experienced a series of system outages during the last two weeks of August which impacted their IVR and telephony systems. This resulted in member disruption that the current vendor is still working to fully resolve. The Health Connector anticipates using the long Columbus Day holiday to transfer call center services to Accenture with Accenture taking calls from members beginning October 12th. He shared that Accenture has completed hiring and is conducting training through September. He then invited Terry Westropp, Managing Director at Accenture, to speak on behalf of the new contact center team.

Mr. Westropp began his remarks by sharing his role as Managing Director of Accenture's Business Process Outsourcing Services business and Health and Public Service sector. He noted Accenture's understanding of the importance of contact center services during the Public Health Emergency (PHE) and Open Enrollment. He continued by sharing that a team of senior experienced delivery executives have been overseeing all aspects of the operation and expressed Accenture's commitment to ensuring a smooth transition.

In response to a question from Mr. Petion related to local hiring and call center location, Mr. Westropp indicated that Accenture is operating in a remote and virtual work environment and has set up the technologies and management procedures to manage that effectively.

In response to a question from Ms. Turnbull about learnings from the last year, Mr. Westropp observed that as service providers transitioned from working in a facility to working virtually, it was necessary to make changes to contact center management procedures. Early on, Accenture adopted technologies that enabled a virtual work environment including technologies that allowed supervisors and managers in an operation to have visibility into remote worker performance. Additionally, contact centers see much great volumes during Open Enrollment. Finally, he noted that there is a higher level of fall-out in virtual environments that service providers need to plan for, and Accenture has adapted its services accordingly.

In response to a follow-up question from Ms. Turnbull, Mr. Westropp indicated the Board members should consider Accenture's performance in terms of metrics, staffing, and technology.

Mr. Gutierrez concluded his remarks by thanking the Board for their support and guidance in moving to Open Enrollment 2022

III. Final 2022 Seal of Approval (VOTE): The "Final Award of the 2022 Seal of Approval (VOTE)" slide deck was presented by Audrey Morse Gasteier, Maria Joy Dawley,

Samuel Adams, and Edith Boucher Calvao. Ms. Gasteier began the presentation by providing an overview of the Seal of Approval (SOA) process and timeline. She reminded Board members of the 2022 Conditional SOA recommendation from July and noted that since then, the Health Connector has received final approved rates from the Division of Insurance which informed the 2022 Final SOA recommendation currently before the Board. Next, Ms. Gasteier noted that the final product shelf for 2022 is largely stable with a ConnectorCare program that continues to offer affordable choices for enrollees up to 300 percent of Federal Poverty Level. For non-group enrollees above that level and small group members, the Health Connector continues to offer a broad range of products from nine medical carriers and two dental carriers. She stated that based on final rates, ConnectorCare base Silver plans are increasing an average of 6.6 percent while unsubsidized and premium tax credit only base plans are increasing an average of 6.9 percent.

Next, Mr. Adams provided an overview of qualified health plan offerings. He recapped information presented at the Conditional SOA meeting in July, noting that most of the plans being offered are designed with standardized cost sharing on Platinum, High Gold, Silver, and Bronze metallic tiers. 2022 QHPs will include expanded coverage of insulin delivery methods at low co-pays, expanding on the existing equity-focused insulin initiative. Additionally, new and closing plan changes are attributed to Fallon Health's change in product strategy. Mr. Adams then summarized Fallon Health's plan changes which impact approximately 1,600 unsubsidized and APTC-only members. Both Fallon and the Health Connector are sending mail and e-mail communications to members to encourage them to check existing provider coverage. Members shopping through the HIX will see a network note associated with Fallon's plans indicating the smaller network. Finally, he noted that these offering changes would not impact Fallon's ConnectorCare program participation.

Mr. Adams then reviewed unsubsidized and APTC-only non-group premium changes, indicating a 6.9 percent increasing before aging and an 8.5 percent increase after aging.

Dr. Chernew commented that these premium increases were more than the Massachusetts health care spending cost target. In response to a question from Dr. Chernew about whether these premium increases were indicative of healthcare spending growth in the state, Mr. Beagan noted that 2022 premium increases are partly attributable to COVID-19 costs going forward including tests, vaccines, boosters, treatment, and PPE. He shared that carriers are concerned about unit cost pressures for hospitals and providers, who are looking for ways to factor in the increased cost of COVID-19-related PPE into their reimbursement rates. Mr. Beagan also stated that it was challenging to disapprove any rates in the 45-day period to finalize rates by August 23rd. In summary, he clarified, 2022 premium increases are based on future price needs and contract negotiations between carriers and providers. Dr. Chernew commented that this approach is likely not sustainable but acknowledged that this is a unique period.

Ms. Turnbull commented that these premium increases are surprising and concerning. She noted that while she understood the difficulties of the rate review process, the

financial performance of health plans in the last year show large profit margins and low loss ratios in individual coverage. In contrast, health plan financial results seem poor in the Medicaid line of business. Ms. Turnbull also noted that 2022 premium increases are twice if not more than the health care cost growth benchmark and represent a failure of the cost control laws implemented in Massachusetts in the last 10 years. She questioned how much of the premium rate increases might be subsidies for carriers' other lines of business that are being borne on the backs of Health Connector members.

Mr. Beagan responded by clarifying that the Division of Insurance (DOI) is seeing similar rate trends in the large and small group markets. He also indicated that in 2020, carriers who had strong financial results due to lower utilization sent rebates to many individuals in the Massachusetts market. For 2021, carriers will do the same for any amount below the Medical Loss Ratio (MLR) of 88 percent. Mr. Beagan stated that in reviewing 2022 rates, the DOI was not looking at financial performance in 2020 or 2021 as much as how those trends affected 2022 costs. He also noted that the DOI used financial strength and actuarial assumptions to push back on some carrier rate filings. In response, Ms. Turnbull stated that rate review is an important tool, but it cannot deal with increasing provider dominance and increasing market power. She also noted that these premium increases are not sustainable.

Ms. Vertes agreed that these premium increases are higher than moderate and disappointing. She stated that no stakeholder in this business should be held exempt from the issues. While the rate review process and focus on insurers is definitely an important factor, increased unit costs are another driver of the projected future increases. This continues to raise the question of how the statewide health care cost growth benchmark is working. She also referenced the Merged Market Advisory Council which was charged with understanding drivers of cost growth in the merged market and recommending solutions. She emphasized that just focusing on insurer profitability and the promise of rebates is missing the opportunity to get at the root cause of increased costs.

Mr. Gaunya stated that health insurance is expensive because health care is expensive. He noted that, actuarially, premium increases are what they are because of underlying provider and insurer contracts. COVID-19 led to lost revenue in the hospital systems which they are trying to recover. He indicated that there is pressure at every end of the market and that the underlying medical and pharmacy trends are unsustainable. Mr. Gaunya also stated that the recent phasing out of pre-ACA rating factors will increase pressure on some in the merged market and the small group market. He concluded his comments by noting that until unit costs are under control, the market will continue to experience cost pressures. In response to Mr. Gaunya, Mr. Gutierrez confirmed that CMS has denied further use of non-ACA compliant rating factors for the next year going forward.

Mr. Chernew noted that the broad frustration around costs is likely beyond what the Board can resolve during this meeting but is a topic that will require on-going focus. Mr. Adams ended his portion of the presentation by sharing a model of premium changes by carrier year over year.

Next, Ms. Dawley shared information about the 2022 ConnectorCare program design, highlighting that there are no changes in carrier participation or service area coverage. She noted that there continues to be regions of the state with only one participating carrier and the Health Connector remains committed to bringing additional carriers with sufficient provider choice to those areas. In 2023 and future years, the Health Connector aims to provide members with equitable access to a range of providers, regardless of income level.

Ms. Dawley then presented ConnectorCare enrollee contributions for 2022, noting that the proposed premium schedule guarantees at least one plan choice at the affordability schedule and offers modest additional support for members selecting higher cost plans. Ms. Dawley also reviewed 2022 Qualified Dental Plans. There were no changes to dental product offerings with the same carriers submitting the same plans as in 2021. She noted that, on average, dental members will experience a rate decrease of one percent.

In response to a question from Ms. Turnbull regarding Delta Dental's rate increase, Mr. Beagan noted that Delta Dental is seeing utilization come back compared to 2020. Delta Dental's projections for 2022 are expecting that utilization will be at a relatively normal rate of increase, and therefore, their premium increases are driven by utilization changes as opposed to unit cost. He added that Delta Dental had an eight or nine percent rate decrease between 2020 and 2021 and in 2022 they are adjusting for that decrease.

Ms. Dawley concluded her presentation sharing next steps and insights for 2023 SOA policy exploration including improvements to ConnectorCare, support of EHS's Behavioral Health Road Map, and implementing plan features to close health gaps based on racial disparities, and furthering opioid use disorder treatment.

With no further questions, the Board motioned and unanimously voted to award the 2022 Final SOA to all recommended QHPs and QDPs proposed by 12 carriers. In delivering her vote, Ms. Fisher noted her shared concerns about premium increases.

- IV. Trends in Health Care Affordability and Premiums in Massachusetts:** Marissa Woltmann presented the slide deck titled, "Trends in Health Care Affordability and Premiums". She began the presentation by providing background on Massachusetts's individual mandate and the Health Connector's role in administering it. She explained that the affordability schedule sets the percentage of income considered affordable for households of various sizes and income ranges with higher income households considered to spend a larger portion of income on coverage. Since 2015, the affordability standards have held steady while the incomes associated with each bracket increase gradually as the federal poverty guidelines increase, driven by changes in the Consumer Price Index (CPI). Ms. Woltmann shared information about how the individual mandate affordability standards are applied in practice during tax time using the Schedule HC. She also provided background information on the premium schedule, which shows the lowest cost plan available through the Health Connector at a variety of ages, family sizes, and regions. In general, the premium schedule reflects premiums for Bronze level plans,

though it does reflect premiums for Catastrophic plans for individuals ages 30 and younger. She noted that while the premium schedule may not reflect everyone's circumstances, it is a very close reflection of what is available to them.

She then presented information on the change in lowest cost premiums between 2015 and 2021, noting 41, 31, and 74 percent increases in regions 1, 2, and 3, respectively. She clarified that an individual's actual experience may reflect higher increases due to aging. She also noted that a Bronze plan in 2015 would be similar to a Silver plan 2021 so in addition to higher premiums, plans would have higher cost-sharing in 2021, as well.

Next, Ms. Woltmann shared additional context on non-group premiums and affordability determinations, emphasizing that premium subsidies are not included in either. She compared the state affordability standard to the percentage of income paid in premium after APTC under the ARP, highlighting their close alignment. Ms. Woltmann then presented a set of examples showing an individual earning \$40,000 per year, a couple earning \$80,000 per year, and a family earning \$100,000 per year and at three different ages in each region over time.

In response to a question from Ms. Turnbull, Ms. Woltmann clarified that the tables presented show what an individual would fill in on their tax form, not accounting for subsidies. She caveated that a member looking for a plan may not see the price in the premium schedule if they qualify for tax credits.

Commissioner Veno commented that it would be interesting to see affordability determinations after the application of APTCs. He noted that rising premiums among the subsidized population are born by subsidies as opposed to the individual member whereas, the unsubsidized population bears the full brunt of premium increases because there is no subsidy available. In response, Ms. Woltmann clarified that the examples presented were created in the context of the individual mandate which does not factor in premium subsidies. She confirmed that premium subsidies do factor in when an individual comes to the Exchange to shop for coverage and may see lower premiums.

Next, Ms. Woltmann shared aggregate individual mandate uninsurance data showing an increase in the proportion of individuals exempt from a penalty because they lacked access to affordable coverage over time (despite the absolute number staying the same). She noted that coverage gains for the lowest income individuals meant that those with unaffordable coverage made up a larger percentage of the uninsured. She also highlighted differences in dynamics among the part year insured who tend to be higher income and are exempt from a penalty due to short gaps in coverage. Ms. Woltmann summarized the data by noting that the only people who should be left in an individual mandate compliance chart are people for whom coverage is unaffordable, as those with an affordable offer of coverage get enrolled.

Ms. Turnbull commented that the data also demonstrates that half the uninsured have income at a level where they likely qualify for subsidized coverage. Ms. Woltmann agreed that many of the uninsured may qualify for subsidized coverage, and that outreach

and education go hand in hand with cost containment tools to reduce the number of uninsured every year.

In response to a question from Ms. Turnbull about tax data, Ms. Woltmann clarified that staff are currently working through 2016 and 2017 data. She noted that a software change at the DOR required the Health Connector rewire existing data infrastructure to analyze the data. Ms. Woltmann then shared high level information on coverage rates from more recent years which showed slow but consistent growth in coverage even before the ARP.

Next, Ms. Woltmann offered information about the affordability of premiums and cost sharing from the member perspective using data from the Health Connector's member experience survey. She also noted growth in the share of members reporting delaying or forgoing care due to cost over time.

In response to a question from Mr. Petion about the survey, Ms. Woltmann clarified that the member experience survey asks questions focused on delaying or forgoing care due to cost or not being able to find a provider.

Ms. Woltmann ended the presentation by offering key takeaways and steps for future work around affordability including working with stakeholders to strengthen the individual market, enhancing outreach work to enroll more individuals, pursuing high-value product design, and analyzing data to shape state and federal policymaking.

Ms. Vertes noted that as health care continues to become less affordable and subsidies continue to increase, state and federal governments are paying the price for not addressing the underlying drivers for health care costs. She emphasized that the Commonwealth should move beyond making observations to taking action to address the cost of health care.

Mr. Petion agreed with Ms. Vertes, commenting that in the past year, there have been very few actions to justify the price increases seen. He noted that most individuals have not used health care in the last year due to concerns related to COVID and limitations on available services, yet there has been an increase in the cost of care. He also emphasized that state agencies should review the drivers of health care costs to facilitate implementation of cost containment strategies.

Ms. Turnbull commented that while the reasons behind increased costs are known, there is a lack of resolve and political will to do anything about it.

Dr. Chernew summarized takeaways from the presentation highlighting that costs are getting worse, and subsidies are critical.

V. Health Care Sharing Ministries' 2020 & 2021 Responses to Minimum Creditable Coverage (MCC) Reporting Requirements: Michael Cannella and Kayla Scire presented the slide deck titled, "Health Care Sharing Ministries Reporting to the Health

Connector in 2020 & 2021”. Mr. Cannella began the presentation by sharing background on MCC. He noted that MCC regulations set cost-sharing, substantive benefits, and coverage administration standards for traditional insurance products and identify programs or methods other than traditional health insurance that a state resident could use to meet their individual mandate obligations. “Health Arrangements Provided by Established Religious Organizations” are one such non-traditional form of paying for services that the MCC regulations have recognized since they were first promulgated in 2007. Until the 2019 MCC amendments, there were no additional criteria that such organizations had to meet for an individual to use their participation in that arrangement to satisfy their individual mandate obligations. The 2019 amendments were prompted by a national uptick Health Care Sharing Ministries (HCSM) participation and Massachusetts’s direct experience with Alieria, an organization marketing itself as a HCSM. Mr. Cannella noted that these developments raised concerns about the risks these types of organizations may pose consumers.

Next, Mr. Cannella reviewed the amended MCC regulations that went into effect in January 2020. As of January 2020, Massachusetts resident can only use health arrangements that meet certain requirements to satisfy their individual mandate obligations. After summarizing the requirements, Mr. Cannella highlighted that the Health Connector has not exercised its discretion to impose any additional criteria. He also noted that the substantive requirements are designed to ensure individuals are only using bona fide arrangements and the reporting requirements are what allows the public and the Health Connector to monitor how those arrangements are operating in Massachusetts.

Mr. Cannella also shared additional information on the reporting requirement which includes questions about membership, operations, and finances as well as an attestation to complying with the other MCC requirements.

In response to a question from Mr. Petion, Mr. Cannella clarified that the MCC regulations as applied to health arrangements like HCSMs only impose certain requirements as to their interactions with consumers and how they represent who they are and what they do. He noted that unlike other methods of financing care, there are no substantive requirements as to how much money needs to be spent on care vs. administrative expenses. The MCC regulations do not contemplate that and otherwise, these health arrangements are not regulated in the same fashion as traditional insurance companies.

Mr. Beagan added that the DOI has concerns about these entities. They are not insurance companies, do not have insurance products, and are not subject insurance regulations. He also noted that they had not developed any actuarial calculations of how they operate. Mr. Beagan also shared that the DOI and Health Connector as well as the Merged Market Advisory Council have discussed implementing new processes to regulate HCSMs. Mr. Beagan expressed concerns about HCSMs that market products in the state and do not report to the Health Connector, leaving individuals without any protection. He added that

the Merged Market Advisory Council report may have some recommendations about how to approach entities like HCSMs moving forward.

Dr. Chernew questioned whether individuals can avoid ACA penalties but not have a plan that meets the ACA actuarial value requirements in one of these health arrangements. Mr. Gutierrez confirmed and clarified that the ACA penalty is now zeroed out but there is state penalty that individuals can avoid.

In response to a question from Ms. Turnbull, Mr. Beagan noted that the legislature may be able to ban these entities or set up some sort of registration or licensing requirement to allow appropriate consumer protections. These registration requirements could be delegated to any state entity including the Health Policy Commission (HPC) or Attorney General. Mr. Beagan clarified that if these entities are a choice that individuals want to have, the state should ensure they are an appropriate or legitimate choice and are following responsible standards.

Next, Ms. Scire presented an overview of the information collected through the HCSM reporting form in 2020 and 2021. She clarified that forms submitted in 2020 reflect information from 2019 and forms submitted in 2021 reflect information from 2020. She noted in 2020, seven HCSMs with at least 2,467 Massachusetts members reported to the Health Connector compared to six HCSMs with at least 2,170 members reported in 2021. Most HCSMs reported charging members extra fees or issuing penalties in certain circumstances most of which were tied to violations of lifestyle agreements or pre-existing conditions. In both reporting years, members paid their HCSM more than the amount the HCSM paid out for members medical bills and about half of medical bills submitted by members were determined eligible for sharing.

Ms. Scire then presented information on HCSM membership based on submitted MCC reporting forms in 2020 and 2021. She highlighted that overall Massachusetts HCSM membership declined between 2020 and 2021 which may be since Medi-Share, which reported the most members in the state in 2020, did not submit a reporting form to the Health Connector in 2021. Ms. Scire emphasized that the membership represented in the data only includes those HCSMs that reported to the Health Connector for the purposes of MCC status. There may be other HCSMs within Massachusetts who the Health Connector does not know about because they did not submit a form. Ms. Scire continued by sharing information about three HCSMs that reported small businesses using their arrangements.

In response to a question from Ms. Turnbull, Ms. Scire clarified that the Health Connector does not know about the total number of HCSMs in the state.

In response to a follow-up question from Ms. Turnbull about national HCSM data, Mr. Beagan noted that there may be some information about HCSMs at the NAIC level, but he has not seen many beyond the ones reporting to the Health Connector.

Next, Ms. Scire shared information about the location of operation and advertisement among the HCSMs reporting to the Health Connector, highlighting that most operated in all 50 states. She noted that most HCSMs reporting to the Health Connector charged members extra fees or issued penalties in certain circumstances. Most HCSMs also reported using third-party vendors or administrative partners and some form of provider contracts.

In response to a question from Dr. Chernew about the members of these arrangements, Ms. Scire clarified that the Health Connector did not collect information to understand whether HCSM members also had separate health insurance. Dr. Chernew noted that the sample size is not enough to spread risk and the finances are likely not enough to pay very serious medical bills for members.

Ms. Scire then provided an overview of HCSM financial information, highlighting that on average, members paid their HCSM 1.8 times in 2020 the amount the HCSM paid out for members' health care bills and 1.4 times the amount in 2021. She noted that costs paid for through HCSM as a proportion of member contributions ranged from 16 to 79 percent in 2020 and 28 to over 100 percent in 2021.

In response to a question from Ms. Turnbull, Ms. Scire clarified that the table titled "Amount Paid Out by HCSM for Members' Health Care Costs as a Percent of Member Contributions" represented Massachusetts data only. She also noted that national data is available for some but not all HCSMs. In a follow-up question from Ms. Turnbull about national data, Ms. Scire noted that largely, the contribution ratios for HCSM national vs. Massachusetts members varies. Ms. Turnbull commented that ratios are expected to be volatile given low membership in these arrangements.

Ms. Scire presented information on HCSM administrative fees. She noted that all HCSMs charged their members administrative fees; however, the fee structure and amount greatly varied. She then summarized HCSM rate negotiation, highlighting that HCSMs either negotiate on behalf of members, have members negotiate their own bills, or have a third-party vendor negotiating medical bills. Ms. Scire concluded the presentation by sharing key takeaways.

In response to a question from Ms. Turnbull about translating data into action, Mr. Gutierrez stated that while next steps are currently unclear, the problems with these entities are made manifest by the data presented. Ms. Turnbull expressed concern that there are no obligations on the entities to assess people who join them to see if they may be eligible for free or subsidized coverage. She noted that there are a variety of ways short of the legislature banning these organizations to create additional consumer protections to help people find their way to adequate health coverage.

In response to a question from Mr. Petion regarding surveying HCSM members, Mr. Gutierrez expressed concern about the prerogatives, privacy, and politics of reaching into these organizations' memberships to directly survey them. He also noted that what is clear in the data is that a vast majority of member claims are being denied as either

unallowable or unpayable. Ms. Turnbull added that there is now an enforcement record against these entities, including through the DOI. She also noted that these entities are employing practices that were outlawed in Massachusetts in the 1980s in some cases.

- VI. Contact Center Implementation Update:** Vicki Coates presented the slide deck titled, “Contact Center: Implementation Update”. Ms. Coates began the presentation by reinforcing the Health Connector’s guiding principle for the new contact center vendor project and reminding the Board of the implementation target date of October 12th, 2021. She presented a refresher of the overall scope and services that will be available through Accenture upon go-live (or Release 1). She noted that additional features would be available to members following the initial go-live for a “Day 2” release targeted for late winter or spring. Ms. Coates also shared a high-level timeline of key activities that would occur between August and the target go-live date. The target go-live date was selected because it occurs over a natural three-day weekend so cutover will not take a normal day of operations, it allows more time to test and validate test results, and it also allows for more targeted training and practice sessions by front line staff.

Ms. Coates continued the presentation by sharing information about each project work track including hiring, training, quality assurance, data migration, phone transfers, development, integration, testing, and CMS approval. Ms. Coates also shared the Health Connector’s go-live readiness plan and criteria.

In response to a question from Ms. Turnbull regarding additional staffing, Ms. Coates indicated that the Health Connector is in active discussions with Accenture about the subsidy loss issue.

In response to a question from Mr. Petion regarding contingencies, Ms. Coates clarified that 320 staff are needed to go-live on October 12th but the Health Connector is aiming to have 380 staff members. She also indicated that over 400 staff members are preparing to go through training and that there will be an extended help desk available for the first few days after go-live.

Dr. Chernew ended the meeting by thanking Health Connector staff for their work.

With no questions or further discussion, the Board motioned and unanimously voted to through roll call to adjourn at 10:57 AM.

Respectfully submitted,

Nikhita Thaper